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§15–105.

(a) In this section, "dual eligibility" means simultaneous eligibility for health insurance coverage under both the Program and Medicare and for which the Department may obtain federal matching funds.

(b) The Department shall adopt rules and regulations for the reimbursement of providers under the Program. However, except for an invoice that must be submitted to a Medicare intermediary or Medicare carrier for an individual with dual eligibility, payment may not be made for an invoice that is received more than 1 year after the dates of the services given.

(c) A provider who fails to submit an invoice within the required time may not recover the amount later from the Program recipient.

(d) (1) The Department shall adopt regulations for the reimbursement of specialty outpatient treatment and diagnostic services rendered to Program recipients at a freestanding clinic owned and operated by a hospital that is under a capitation agreement approved by the Health Services Cost Review Commission.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, the reimbursement rate under paragraph (1) of this subsection shall be set according to Medicare standards and principles for retrospective cost reimbursement as described in 42 C.F.R. Part 413 or on the basis of charges, whichever is less.

(ii) The reimbursement rate for hospital outpatient oncology, diagnostic, and rehabilitative services that the hospital transferred to an off–site facility prior to January 1, 1999, shall be set according to the rates approved by the Health Services Cost Review Commission if:

1. The transfer of services was due to zoning restrictions at the hospital campus;

2. The off–site facility is surveyed as part of the hospital for purposes of accreditation by the Joint Commission; and

3. The hospital notifies the Health Services Cost Review Commission in writing by June 1, 2013, that the hospital would like the services provided at the off–site facility to be subject to Title 19, Subtitle 2 of this article.

(e) (1) In this subsection, "provider" means a community–based program or an individual health care practitioner providing outpatient mental health treatment.

(2) For an individual with dual eligibility, the Program shall reimburse a provider the entire amount of the Program fee for outpatient mental health treatment, including any amount ordinarily withheld as a psychiatric exclusion and any copayment not covered under Medicare.

(f) This section has no effect if its operation would cause this State to lose any federal funds.

(g) The Program shall pay the rates set by the Health Services Cost Review Commission for hospital services, as defined in § 19–201 of this article, provided at:

(1) A freestanding medical facility pilot project authorized under § 19–3A–07 of this article prior to January 1, 2008; and

(2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015.

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